necks elsewhere in the system. In Mr. Turner's hospital, for example, it could be more nurses in the operating theatres, or several prefabricated Honeywell theatres added to the plant, or both, and these could be financially feasible as each day saved in hospital costs £7.

Discussions from the Ministry and the regional board on adequacy of resources in the Liverpool region focus on beds. Our studies agree with Mr. Turner's opinion that there is no shortage of surgical beds in his region. We are now examining other bottlenecks to the steady flow of patients through the hospital system, for example, waiting for outpatient appointments, *x*-ray, or laboratory tests, for theatre sessions, and the discharge procedure. Moreover, the very lack of relationship between the allocation and the site of beds, outpatient sessions, and theatre sessions in the several hospitals covered by one specialist may mitigate against an effective weekly pattern of work for the surgeon and his dispersed resources.

It is puzzling that so little examination has been made over the years on such bottlenecks, particularly when the system is so rigid, and hospital treatment has been changing so quickly, becoming more complex as well as more effective. A thoughtful letter from a practising surgeon indicates the inadequacy of management skills in meeting the title above—and also the defects in communication. I hope the B.M.A. will continue the debate.—I am, etc.,

Medical Care Research Unit, University of Manchester, Manchester 13. R. LOGAN.

REFERENCE

1 Logan, R. F. L., *Med. Trib.*, 1967, no. 15, p. 12.

SIR,—A request for an E.N.T. outpatient consultation was made on 9 May 1967. The appointment has been given for 7 November 1967. Is this a record for the United Kingdom ?—I am, etc.,

Liverpool. G. E. CRAWFORD.

Reference to the Coroner

SIR,—How welcome is Dr. N. F. Coghill's letter on the subject of coroners' necropsies (3 June, p. 637). An advantage of working in more than one hospital district is the opportunity this gives to study the somewhat different rules and practice of different coroners. The coroner without a medical qualification often seems reluctant to use the hospital pathologist with full histological facilities at his disposal. Instead, he not infrequently calls in an outside pathologist who often, unavoidably, does the necropsy at both a time and a place which are inconvenient for the clinicians who cared for the living patient. Even when such a necropsy is done in the hospital post-mortem room, convenient timing of the examination is generally more difficult than when it is done by the hospital's own morbid anatomist. Moreover, it is not uncommon to find that no histological sections are made from important pathological material and that the subsequent report is not available in the hospital records. Indeed, not only does the hospital have to make official request for a copy of the necropsy report, but the hospital authority is required to pay a fee for that report.

A further problem posed by some "coroners' pathologists" is that those who are medicolegally orientated seem to be geared to quite a different type of pathology from that done by the skilled hospital morbid anatomist. A "list" of necropsies, hastily performed by some itinerant pathologist, is hardly conducive to that patient observation and high standard of skill which we are accustomed to expect from our hospital morbid anatomist colleagues. I have seen what one can only describe as standard pathology missed or completely misinterpreted in such circumstances. In making these criticisms I do, however, clearly recognize that certain cases are attended by circumstances which render it imperative or strongly advisable to call in some independent pathologist. In fact, it is often the hospital pathologist himself who brings such circumstances to the notice of the coroner.

As to the compulsory notification of certain deaths, I know of one district in which the use of the words "toxaemia," "gangrene," or "peritonitis" on a death certificate (even when the cause is precisely designated) compels the registrar of deaths to refer such cases to the coroner. An inevitable result of such an *ipse dixit* by a coroner is that a doctor who is properly sensitive to the feelings of the relatives may well insert a wording on the death certificate which, though medically less accurate, avoids the possibility of upsetting the relatives by a quite unnecessary reference to the coroner.

It has for many years been my strong contention that medically qualified coroners are far better able to assess subtle and complex medical issues than are those with a purely legal qualification. In these circumstances it would surely be wiser to appoint only coroners with medical qualification and experience as well as legal training.—I am, etc.,

Radlett, Herts. REGINALD S. MURLEY.

Treatment of Choriocarcinoma

SIR,—Dr. W. Wallace Park's criticism (1 April, p. 52) of our recent paper (4 March, p. 521) has arrived in Singapore, and a reply is appropriate even though delayed. We note that he has completely missed the theme of our article, which was primarily meant to evaluate the place of hysterectomy in the treatment of trophoblastic malignancy. There was no intention of comparing our results with those of other centres, or of comparing cure rates in our own three groups of patients.

Our examination of the published works of Bagshawe,[1] Hertz *et al.*,[2] and Brewer *et al.*,[3] and our own experience in studying over 500 patients since 1959, leave us in no doubt as to the value of timely hysterectomy in selected cases. We have stated the principles guiding our choice of method, "the extent of the disease, the presence of a uterine growth, and the need for further child-bearing." These terms are intelligible to all clinicians. We weigh each factor in turn and consider the advisability of hysterectomy on the sum total of the pros and cons.

Park states that we "contend that hysterectomy should be used more often than it nowadays is, particularly in specialized centres. ... ." This is a far cry from our plea that the matter be reviewed "before hysterectomy is abandoned altogether." What we do contend is that the claims that "hysterectomy may impair the response to chemotherapy and worsen the cure rate" are not applicable to many parts of the world, especially the less well developed areas which do not have the facilities of specialized chemotherapy centres. We have no doubt that the gynaecologists in Malaya, Hong Kong, and even parts of Britain, faced with a uterine choriocarcinoma, should still employ hysterectomy, besides chemotherapy.

The "range of meaning" given to the term "choriocarcinoma" has changed since Ewing's day, and is changing still. Not too long ago eminent pathologists on both sides of the Atlantic considered the disease to be almost invariably fatal, and indeed some used to regard a cure rate in excess of 10% with scepticism. Not so today. Surely the "range of meaning" has to move with the advancement of knowledge—hence our classification, which has been documented.[4,5]

Choriocarcinoma is a vital, dynamic, and versatile disease process. It must be studied in the living body. A complete and balanced concept cannot be acquired except by studying patients as well as pathological material. We have learnt to treat all chorionic malignancies with respect, whether villous or non-villous.[6]

Park belabours the necessity of comparing our results with those from other centres. We do not consider this fruitful at present or possible, and our paper was not written with this aim in view. The classifications in current use vary from centre to centre, and the latest one by Park himself, if adopted, would merely add chaos to confusion.[7]

Finally, Park leaves us a little puzzled by banning the use of the term "trophoblast," which he himself employs repeatedly in his letter.—We are, etc.,

W. S. H. TOW.
W. C. CHENG.

University Department, Kandang Kerbau Hospital, Singapore 8.

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2 Hertz, R., Ross, G. T., and Lipsett, M. B., *Ann. N.Y. Acad. Sci.*, 1964, **114**, 881.
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4 Tow, W. S. H., *Aust. N.Z. J. Obstet. Gynaec.*, 1965, **5**, 165.
5 —— *J. Obstet. Gynaec. Brit. Cwlth*, 1966, **73**, 1000.
6 —— ibid., 1961, **68**, 225.
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Medical Aspects of Divorce and Nullity

SIR,—The article (20 May, p. 491) by a Queen's Counsel on this rather complicated subject was particularly lucid and informative. There is, however, one point which requires clarification.

When discussing the grounds for a decree of nullity your writer states that one ground occurs "Where in the case of a marriage celebrated before the commencement of the Mental Health Act, 1959, either party was at the time of the marriage . . . a mental defective within the meaning of the Mental Deficiency Acts, 1913 to 1938. . . ." I would like to point out that the Matrimonial Causes Act lays down that where a petition is brought on this ground the court must be satisfied that proceedings were started within a year of the marriage.